RELEVANCE OF TRAUMA TO STAKEHOLDERS SERVING COURT INVOLVED YOUTH

Allison Sampson, PhD, LCSW, LICSW, CSOTP

Family Preservation Services of VA

WHAT'S ALL THE "TRAUMA" BUZZ ABOUT …

- Over the last 10 -20 years there has been an explosion of information provided to us about the relevance and impact of trauma on the brain, on relationships, and on our development …
- This explosion has resulted from new abilities to see the brain in ways that we are better connecting life experiences and over all well being (Physical and Mental Health)

TRAUMA
CHILD WELFARE AND JUVENILE JUSTICE

Resources for Education and Development

NCTSN CONTRIBUTIONS …

This project was funded by the Substance Abuse and Mental Health Services Administration (SAMHSA), US Department of Health and Human Services (HHS). The views, policies, and opinions expressed are those of the authors and do not necessarily reflect those of SAMHSA or HHS.

Established by Congress in 2000, the National Child Traumatic Stress Network (NCTSN) is a unique collaboration of academic and community-based service centers whose mission is to raise the standard of care and increase access to services for traumatized children and their families across the United States. Combining knowledge of child development, expertise in the full range of child traumatic experiences, and attention to cultural perspectives, the NCTSN serves as a national resource for developing and disseminating evidence-based interventions, trauma-informed services, and public and professional education.

CHILD WELFARE TOOLKIT

Child Welfare Toolkit (2008)Toolkit was developed by the National Child Traumatic Stress Network in collaboration
with

- Rady Children's Hospital, Chadwick Center for Children and Families

-Child and Family Policy Institute of California (CFPIC)

- California Social Work Education Center (CFPIC)

- California Institute for Mental Health (CIMH)

JUVENILE JUSTICE SAFESTART RESOURCES

- http://www.safestartcenter.org/resources/toolkit-court-involved-youth-exposure-violence.php

- http://www.nctsn.org/resources/topics/juvenile-justice-system

- Summer 2013 Today Magazine WEB.pdf

NCTSN AND RESOURCES FOR LEARNING JUVENILE JUSTICE

http://learn.nctsn.org/index.php

Screening and Assessment in Juvenile Justice Settings

Juvenile Justice Resource Site

Think Trauma Toolkit: Training for Staff in Juvenile Justice Settings

INFORMATION AND SLIDE PART OF DR. ALLISON SAMPSON'S TRAUMA PRESENTATION

DEFINING TRAUMA …

WHAT IS CHILD TRAUMATIC STRESS?

- Child traumatic stress refers to the *physical and emotional responses* of a child to events that threaten the life or physical integrity of the child or of someone critically important to the child (such as a parent or sibling).

- Traumatic events overwhelm a child's capacity to cope and elicit feelings of terror, powerlessness, and out-of-control physiological arousal.

WHAT IS CHILD TRAUMATIC STRESS, CONT'D

- A child's response to a traumatic event may have a profound effect on his or her perception of self, the world, and the future.
- Traumatic events may affect a child's:
  - Ability to trust others
  - Sense of personal safety
  - Effectiveness in navigating life changes

TYPES OF TRAUMATIC STRESS

- **Acute trauma** is a single traumatic event that is limited in time. Examples include:
  - Serious accidents
  - Community violence
  - Natural disasters (earthquakes, wildfires, floods)
  - Sudden or violent loss of a loved one
  - Physical or sexual assault (e.g., being shot or raped)
- During an acute event, children go through a variety of feelings, thoughts, and physical reactions that are frightening in and of themselves and contribute to a sense of being overwhelmed.

TYPES OF TRAUMATIC STRESS, CONT'D

- **Chronic trauma** refers to the experience of multiple traumatic events.
- These may be multiple and varied events—such as a child who is exposed to domestic violence, is involved in a serious car accident, and then becomes a victim of community violence—or longstanding trauma such as physical abuse, neglect, or war.
- The effects of chronic trauma are often cumulative, as each event serves to remind the child of prior trauma and reinforce its negative impact.

TYPES OF TRAUMATIC STRESS, CONT'D

- **Complex trauma** describes both exposure to chronic trauma—usually caused by adults entrusted with the child's care—and the impact of such exposure on the child.
- Children who experienced complex trauma have endured multiple interpersonal traumatic events from a very young age.
- Complex trauma has profound effects on nearly every aspect of a child's development and functioning.

Source: Cook et al. (2005). *Psychiatr Ann,35*(5):390-398.

Variables that impact of trauma

OTHER SOURCES OF STRESS

OTHER SOURCES OF ONGOING STRESS

- Children in the child welfare system frequently face other sources of ongoing stress that can challenge workers' ability to intervene. Some of these sources of stress include:
  - Poverty
  - Discrimination
  - Separations from parent/siblings
  - Frequent moves
  - School problems
  - Traumatic grief and loss
  - Refugee or immigrant experiences

“Henry” and Some Data

http://www.ovc.gov/pubs/ThroughOurEyes/index.html

TRAUMA AND CHILD WELFARE

PREVALENCE OF TRAUMA—UNITED STATES

- Each year in the United States, more than 1,400 children—nearly 2 children per 100,000—die of abuse or neglect.
- In 2005, 899,000 children were victims of child maltreatment. Of these:
  - 62.8% experienced neglect
  - 16.6% were physically abused
  - 9.3% were sexually abused
  - 7.1% endured emotional or psychological abuse
  - 14.3% experienced other forms of maltreatment (e.g., abandonment, threats of harm, congenital drug addiction)

Source: USDHHS. (2007) *Child Maltreatment 2005;* Washington, DC: US Gov't Printing Office.

U.S. PREVALENCE, CONT'D

- One in four children/adolescents experience at least one potentially traumatic event before the age of 16.[1]
- In a 1995 study, 41% of middle school students in urban school systems reported witnessing a stabbing or shooting in the previous year.[2]
- Four out of 10 U.S. children report witnessing violence; 8% report a lifetime prevalence of sexual assault, and 17% report having been physically assaulted.[3]

1. Costello et al. (2002). *J Traum Stress*;5(2):99-112.
2. Schwab-Stone et al. (1995). *J Am Acad Child Adolesc Psychiatry;34*(10):1343-1352.
3. Kilpatrick et al. (2003). US Dept. Of Justice. http://www.ncjrs.gov/pdffiles1/nij/194972.pdf.

PREVALENCE OF TRAUMA IN THE CHILD WELFARE POPULATION

- A national study of adult “foster care alumni” found higher rates of PTSD (21%) compared with the general population (4.5%). This was higher than rates of PTSD in American war veterans.[1]

- Nearly 80% of abused children face at least one mental health challenge by age 21.[2]

1. Pecora, et al. (December 10, 2003). *Early Results from the Casey National Alumni Study*. Available at: http://www.casey.org/NR/rdonlyres/CEFBB1B6-7ED1-440D-925A-E5BAF602294D/302/casey_alumni_studies_report.pdf.

2. ASTHO. (April 2005). *Child Maltreatment, Abuse, and Neglect*. Available at: http://www.astho.org/pubs/Childmaltreatmentfactsheet4-05.pdf.

PREVALENCE IN CHILD WELFARE POPULATION, CONT'D

- A study of children in foster care revealed that PTSD was diagnosed in 60% of sexually abused children and in 42% of the physically abused children.[1]

- The study also found that 18% of foster children who had not experienced either type of abuse had PTSD,[1] possibly as a result of exposure to domestic or community violence.[2]

1. Dubner et al. (1999). *JCCPsych;*67(3): 367-373.
2. Marsenich (March 2002). *Evidence-Based Practices in Mental Health Services for Foster Youth*. Available at: http://www.cimh.org/downloads/Fostercaremanual.pdf.

FOSTER CARE OUTCOMES AND DATA

Based on Health and Human Services data (2005), children entering foster care ….

60% will return home

15% will be adopted

Remaining children “age out” of foster care

(19,000 per year)

IMPACT OF BEING IN CHILD WELFARE SYSTEM

- 25% will be incarcerated within first 2 years of aging out of the system
- More than 20% will become homeless
- Only 58% will have a High School Diploma
- Less than 3% will have a college education by age of 25
- Many will re-enter the system as parents
- For children under age of 5, increase likelihood of developmental delays 13-62% compared to 4-10%

1) Conradi, L. (2012) Chadwick Trauma Informed System Project p. 54
2) Leslie et. al. (2005). *Developmental and Behavioral Pediatrics 26*(3), 177-185

FOSTER CARE AND FAMILY PRESERVATION

- Area of great focus is on balance between family preservation and child removal

- Increased knowledge of parental protective factors and trauma informed practice are being encouraged utilized with the birth parents given positive parental involvement increases positive outcomes for children

- Entering into the Child Welfare System and Foster Care are traumas, often including multiple placements that lead to problems for child development on top of the trauma child experienced in their home

- Some studies in Illinois looked at “close margin” cases where investigator may view removal of a child differently. Children remaining in the home demonstrated increased well-being, especially older children (lower risk of delinquency and adult criminal involvement, higher earnings and employment as an adult, possible relationship to lower rate of teen pregnancy) Doyle, J. (2007, 2008)

BIRTH PARENT INVOLVEMENT

- Many studies indicate that caregiver functioning is a major predictor of child functioning after child experiences a trauma (Linares et al. 2001, Lieberman, Van Horn, & Ozer 2005)

- Birth parent involvement can improve children's depression and lower their externalizing behavior problems (McWey, Acock, & Porter 2010)

- See NCTSN Guide for Attorneys and Judges on Birth Parents and “What Children in Foster Care Want You to Know”

MISMANAGEMENT OF TRAUMA

HENDRICK, H. (2012) *CREATING TRAUMA-INFORMED CHILD WELFARE SYSTEMS, P. 6*

- - Reduces likelihood of reunification (1)
- - Increases placement instability (2)
- - Increase in restrictive placements (3)
- - Increases likelihood of using stronger psychotropic medications (4)
- - Increases child perpetuating intergenerational cycle of abuse and neglect when they become a parent (5)

1) Rubin, O'Reilly, Luan, & Localio (2007) *Pediatrics, 119* (2) 336-344
2) Hartnett, Leathers, Falconnier & Testa (1999) *Placement Stability Study.*
3) Pecora et al. (2005) www.nxtbook.com/nxtbooks/casey/alumnistudies/
4) Raghavan et al. (2005) *Journal of Child and Adolescent Psychopathology, 15*(1), 97-106
5) Fang & Corso (2007) *American Journal of Preventative Medicine, 33*(4), 281-290

“OUR KIDS” IN JUVENILE JUSTICE

“ I am a child” Poem

TRAUMA AND JUVENILE JUSTICE

- A growing body of research indicates that victims of violence are more likely than their peers to also be perpetrators of violence, and that individuals most likely to be victims of personal crime are those who report the greatest involvement in delinquent activities (ABA, 2000; Shaffer and Ruback, 2002; Wiebush et al., 2001).

“OUR KIDS” IN JUVENILE JUSTICE

- Studies with antisocial youth have found self reported trauma exposure ranging from 70% to 92% (Greenwald, 2002)

- Antisocial youth have high rates of Post Traumatic Stress Disorder (PTSD) ranging from 24% to 65% (Greenwald, 2002)

- Research has indicated high levels of trauma in the experiences of conduct-disorder youth (Bowers, 1990; McMackin, Morissey, Newman, Erwin, & Daley, 1998; Rivera & Widom, 1990; and Steiner, Garcia, & Matthews, 1997)
- Research suggests that anger and violent acting out often are symptoms of PTSD (Chemtob, Novaco, Hamada, Gross, & Smith, 1997)

INFORMATION AND SLIDE PART OF DR. ALLISON SAMPSON'S TRAUMA PRESENTATION

TRAUMA AND JUVENILE DELINQUENCY

- Research shows that childhood exposure to domestic and community violence, for example, can cause children to engage in aggressive behavior, suffer from problems such as depression and anxiety, have lower levels of social competence and self-esteem, experience poor academic performance, and exhibit posttraumatic stress symptoms such as emotional numbing and increased arousal (Colley-Quille et al., 1995; ABA, 2000; Osofsky, 1999).

CHILD WELFARE AND CORRECTIONS

Systems Integration Initiative (SII) launched at the Child Welfare League of America in 2000 through the support of the John D. and Catherine T. MacArthur Foundation

Crossover Youth Practice Model (CYPM) by CJJR in partnership with Casey Family Programs in 2009.

http://cjjr.georgetown.edu/pdfs/msy/AddressingtheNeedsofMultiSystemYouth.pdf

CROSS-OVER YOUTH

(HERZ, LEE, LUTZ, STEWART, TUELL, & WIIG, PP 2-3)

- Also known as dually-involved youth
- Majority are male
- Disproportionate are female (third to almost one half)
- Disproportionate number are children of color
- Majority have special education needs, problems in school
- Majority have mental health diagnosis/substance abuse issues
- Significant number have witnessed interpersonal violence
- Need of more intense services

PATHWAYS BETWEEN 2 SYSTEMS

(Herz, Lee, Lutz, Stewart, Tuell, & Wiig, p 3, Figure 2)

Example of the many pathways between 2 systems

THE FUTURE FOR “OUR KIDS” ….

- Being abused or neglected as a child increased the likelihood of arrest as a juvenile by 59 percent and as an adult by 28 percent, and for a violent crime by 30 percent. The abused and neglected cases were younger at first arrest, committed nearly twice as many offenses, and were arrested more frequently (Widom, 1995; Widom and Maxfield, 2001).

DATA FROM THE NATIONAL SURVEY OF ADOLESCENTS (KILPATRICK ET AL., 2003B)

- 47.2 percent of the sexually assaulted boys reported engaging in delinquent acts, compared with only 16.6 percent of those not sexually assaulted
- The rate of girls who had been sexually assaulted and then committed delinquent acts was 19.7 percent, five times higher than the rate of girls who had not been sexually assaulted (4.8 percent).
- The percentage of boys who were physically assaulted and had ever committed an Index offense was 46.7 percent, compared to 9.8 percent of boys who were not assaulted.
- 29.4 percent of physically assaulted girls reported having engaged in serious delinquent acts at some point in their lives, compared with 3.2 percent of nonassaulted girls.
- About one third (32 percent) of boys who witnessed violence reported ever engaging in delinquent acts, compared with only 6.5 percent of boys who did not witness violence.
- About 17 percent of girls who witnessed violence reported lifetime delinquent behavior, compared with 1.4 percent of girls who did not witness violence.

TRAUMA IMPACTS LEARNING AND ACADEMIC OUTCOMES

- Decreased IQ and reading ability

(Delaney-Black et al., 2003)

- Lower grade-point average (Hurt et al., 2001)
- More days of school absence (Hurt et al., 2001)
- Decreased rates of high school graduation (Grogger, 1997)
- Increased expulsions and suspensions (LAUSD Survey)

SUSPENSION AND EXPULSION

- Attachment to school and peers is correlated with school success and reduces likelihood of disciplinary involvement

- Suspended students are twice as likely to drop out of school and

TRAUMA

Is it about just them … or about all of us

ADVERSE CHILDHOOD EXPERIENCES

FELITTI, V. J., & ANDA, R. F. (2010)

Bigger Scope (n=17,337)

- 2/3rd of folks responding reported at least 1 ACE factor
- 1 in 6 had 4 or more ACE factors
- Factors are linked to higher risks for medical conditions like smoking, severe obesity, and heart disease
- Factors are linked higher risk for substance abuse, depression and suicide attempts
- MAJOR PUBLIC HEALH ISSUE

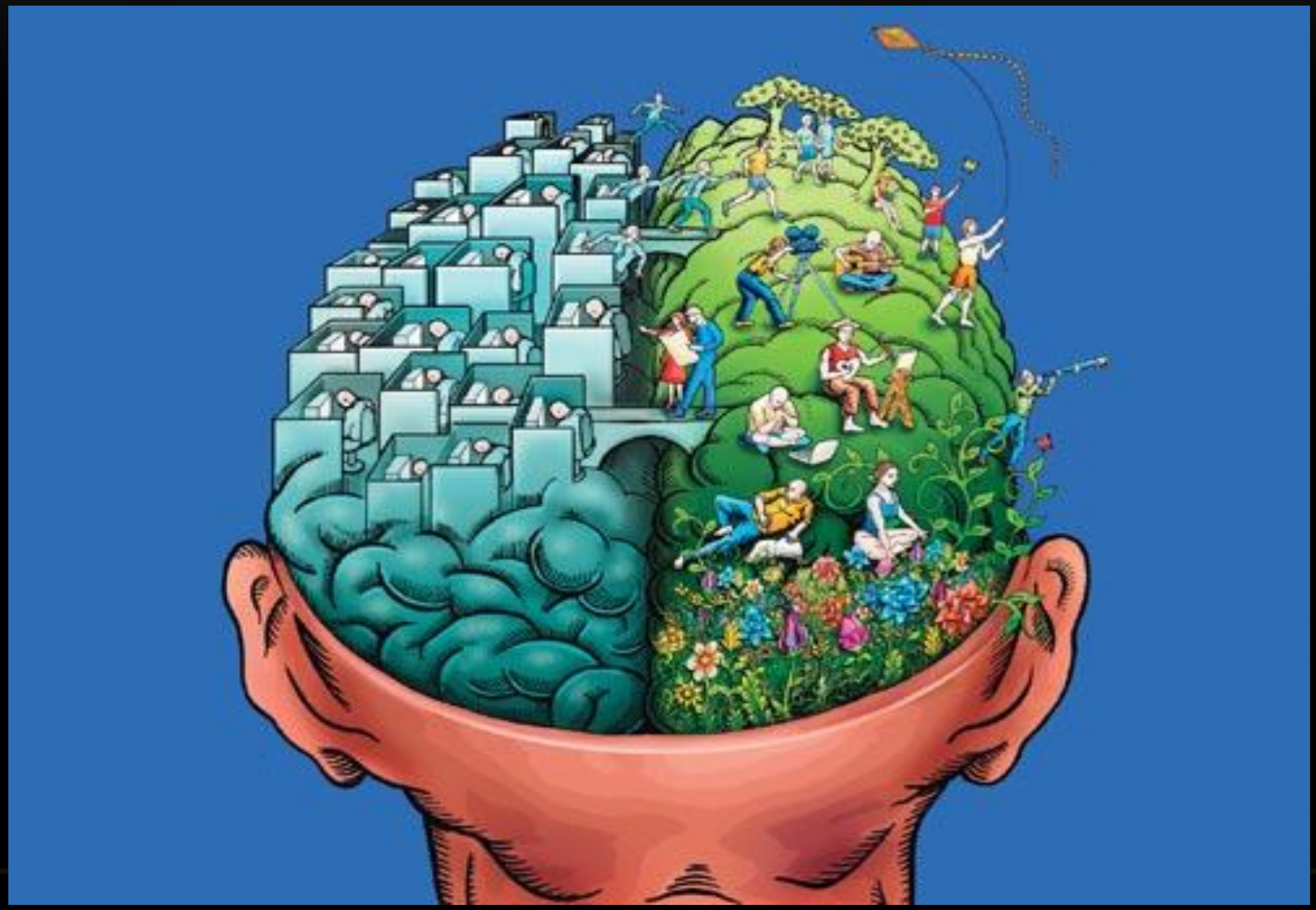
- Refer back to Trauma Infographic
- http://www.jumpstarttulsa.com/ACE_Study.htm
- http://www.cdc.gov/ace/index.htm

TRAUMA PRESENT … THE BRAIN

- PERRY's PET SCAN
  - http://www.childwelfare.gov/pubs/issue_briefs/brain_development/effects.cfm

- CALM CHILD
- TERRIFIED CHILD
- VUNERABILITY MOUNTAIN

RIGHT AND LEFT HEMISPHERE



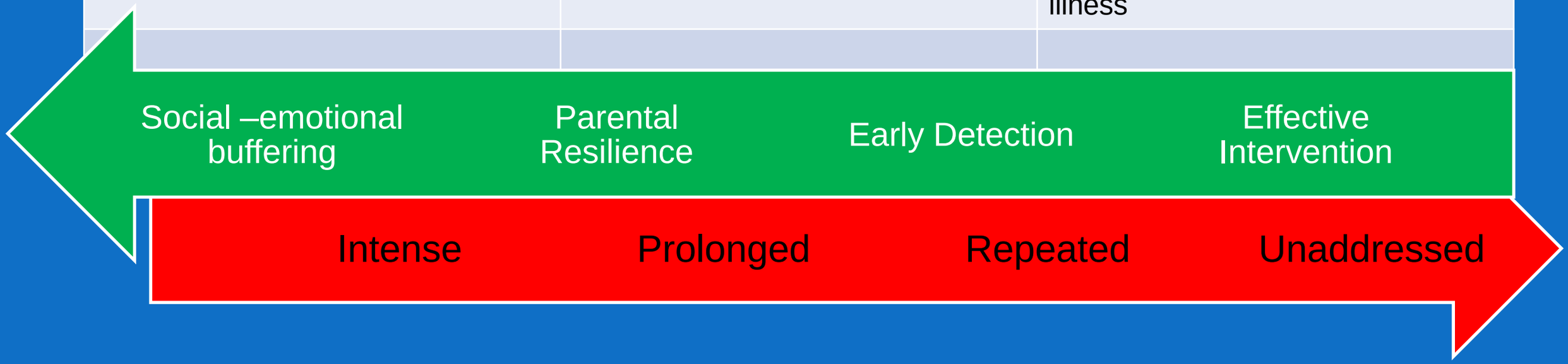
INFORMATION AND SLIDE PART OF DR. ALLISON SAMPSON'S TRAUMA PRESENTATION

BRAIN AND STRESS

- When stress is predictable and moderate, stress can facilitate resiliency and enhance memory
- When stress is unpredictable and severe, stress can create vulnerability and memory impairment
- Severe and chronic stress in childhood via multiple traumas from caregivers can impact affect regulation, interpersonal relationship skills, and states become traits (fight/flight/freeze… disassociation or hyper arousal)

Types of Stress

Positive Stress	Tolerable Stress	Toxic Stress
Normal and essential part of healthy development	Body's alert systems activated to a greater degree	Occurs with strong, frequent or prolonged adversity
Brief increases in heart rate and blood pressure	Activation is time limited and buffered by caring adult	Disrupts brain architecture and other organ systems
Mild elevations in hormonal levels	Brain and organs recover	Increased risk of stress-related disease and cognitive impairment
Example: Tough test at school or a playoff game	Example: Death of a loved one, divorce, natural disaster	Example: abuse, neglect, caregiver substance dependence or mental illness



Information and slide part of Harris (2013) Buzz on Brain and Babies Presentation

TRAUMA PRESENT … ATTACHMENT

Many argue that these early relationships (experiences) shape neuronal circuits which regulate emotional and social functioning

ATTACHMENT'S PURPOSE

SIEGEL, 1999

Evolutionary Level – biological

Infant Survival (Bowlby)

Mind Level – biological and social

- Caregiver's brain helps child's brain to organize regulation
- Caregiver's brain teaches child self-soothing
- Child experience of safety allows for exploration
- Socialization
- Mirror Neurons

What does this mean for children who have experienced trauma?

MEMORY

Explicit Memory

- Semantic: Factual information
- Autobiographical: Sense of self in time

Implicit Memory

- Somatic: Sense of body at time
- Perception: Senses
- Behavioral: What we did with our body

A PERSON'S RESPONSE TO PERCEIVED DANGER

Trauma Event

Danger Response

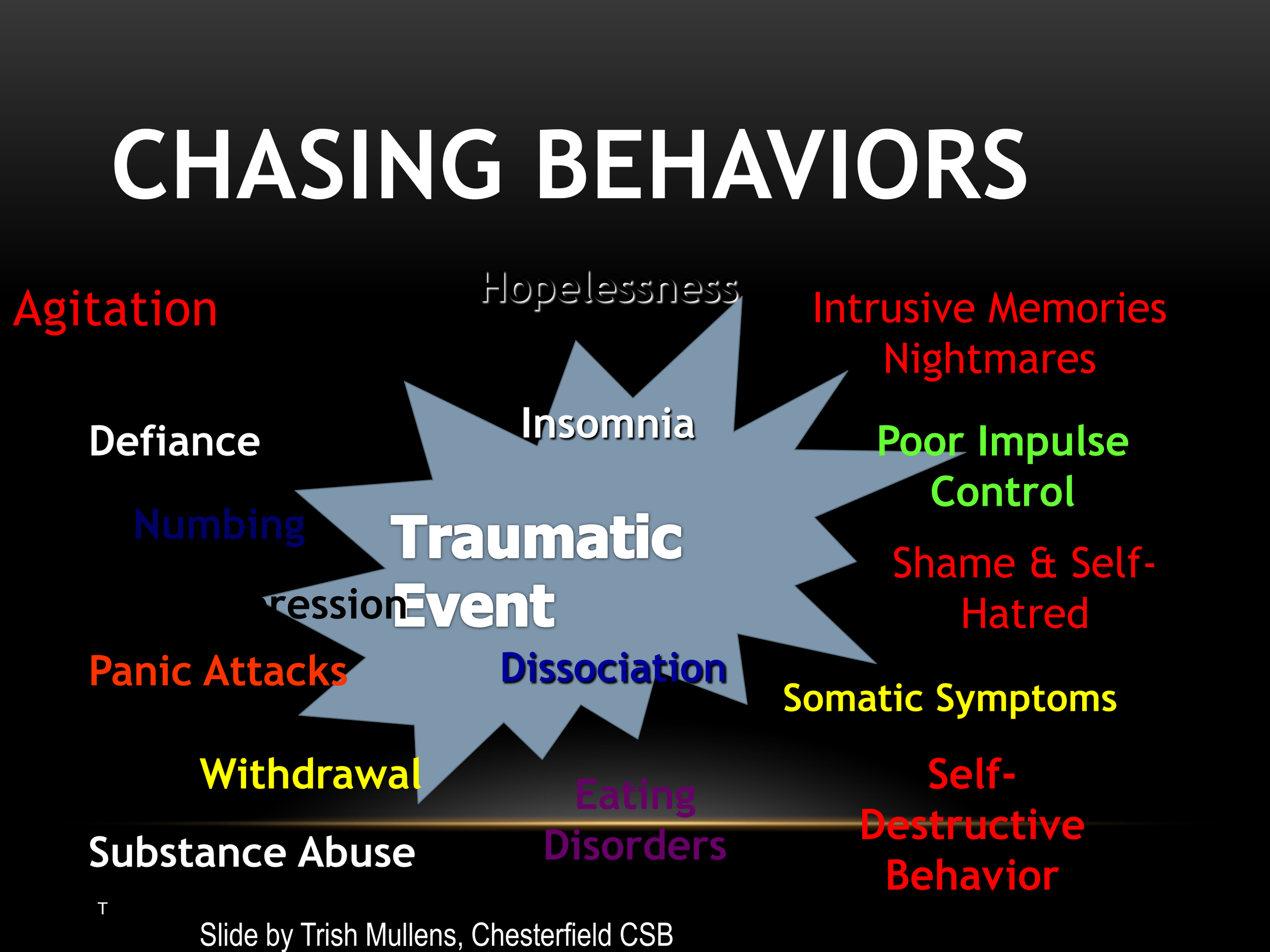
Fight **Flight** **Freeze**

Aggression **Run Away** **Dissociate**

Verbal attack **Substance Abuse** **Non-emotionality**

Slide from Ellen Williams, LCSW
Center for Child & Family Services

CHASING BEHAVIORS



Slide by Trish Mullens, Chesterfield CSB

WE MUST RESPOND TO THE NEED

Not react to the behavior

TRAUMA PRESENT … KEY ELEMENTS OF TIC

Five Core Values (Fallot, 2009)

1) Safety
2) Trustworthiness
3) Choice
4) Collaboration
5) Empowerment

The needs of the adults and caregivers with trauma ….

are no different

CROSS-GENERATIONAL TRAUMA

HENDRICKS (2012) CHAPTER 12 OF *CREATING TRAUMA INFORMED CHILD WELFARE SYSTEMS*
USING TRAUMA INFORMED SERVICES TO INCREASE PARENTAL PROTECTIVE FACTORS

Women who have experienced trauma are more likely to self- medicate with a substance (55-99%) (1)

Intergenerational transmission of trauma (Depression, PTSD) (2)

Unresolved childhood trauma can lead to reenactments with partners in adult relationships and/or with their children (3)

Unresolved childhood trauma can lead to difficulty forming secure attachments with their children (4)

Childhood trauma can result in parenting styles that include threats & violence (2)

Childhood sexual abuse survivors can miss “red flags” of sexual abuse with their own children due to avoidance of trauma memories themselves (2)

1) Najavits, Weiss, & Shaw (1997) *The American Journal on Addiction, 6* (4), 273-283
2) Hendricks, A. (2012). *Using Trauma-Informed Services to Increase Parental Factors (pp. 89-91)*
3) Walker (2007) Journal of Social Work Practice, 21 (1), 77-87.
4) Main & Hess (1990) In M. Greenberg, D. Cicchetti, & E. Cummings (Eds.), *Attachment in the preschool years: Theory, research, and intervention (*pp. 121-160)

BIG PICTURE WITH CAREGIVERS

- Often the caregivers … are the kids we as a system “missed”
- They come to us with their own trauma histories
- Successful outcomes with our clients means successful work with the family
- Screening all caregivers and finding them services is critical to the prevention/treatment/reduction of recidivism for children entering the juvenile justice system

CROSS-GENERATIONAL TRAUMA

HENDRICKS (2012) CHAPTER 12 OF *CREATING TRAUMA INFORMED CHILD WELFARE SYSTEMS*
USING TRAUMA INFORMED SERVICES TO INCREASE PARENTAL PROTECTIVE FACTORS

Caregiver functioning following a child's exposure to trauma is a major predictor of child's functioning (1 & 2)

If we want to improve a child's outcome, we must address parent's trauma history … failure to do so can result in (2) …

- Failure to engage in treatment services
- An increase in symptoms
- An increase in management problems
- Retraumatization
- An increase in relapse
- Withdrawal from service relationship
- Poor treatment outcomes

1) Linares et al (2001) *Child Development, 72, 639-652*
2) Liberman, Van Horn, & Ozer (2005) *Development and Psychopathology, 17*, 385-396
3) Hendricks, A. (2012) pp. 91

TRAUMA AND PROFESSIONALS

Bride (2007) did a study of master's level social workers licensed in a southern state. The study found that…

- 70.2% of workers experienced at least one symptom of STS in the previous week
- 55 % met the criteria for at least one of the core symptom clusters
- 15 .2% met the core criteria for a diagnosis of PTSD.

- The intrusion criterion was endorsed by nearly half of the respondents.

- The most often reported symptoms were intrusive thoughts, avoidance of reminders of clients, and numbing responses.

PERRY AND COST OF CARING

HTTP://CHILDTRAUMAACADEMY.COM/COST_OF_CARING/INDEX.HTML

Lesson 3: **Self-Care Strategies for Combating Secondary Trauma**

http://www.childtraumaacademy.com/cost_of_caring/lesson03/page03.html

Self-Care Strategies for Combating Secondary Trauma: An overview

Below, please find a few of the possible, positive ways you can address stress. Jot down the things you do (or will begin making a point to do) in order to better care for yourself. List additional items within each column.

Physical	Psychological	Emotional	Workplace
Sleep well	Self-reflect	See friends	Take breaks
Eat well	Read for pleasure	Cry	Set limits
Exercise	Say "No"!	Laugh	Get peer support
Walk/Jog	Smile	Praise yourself	Get supervision
Dance	Solitude	Meditate	Use vacations
Others:	Others:	Others:	Others:

INFORMATION AND SLIDE PART OF DR. ALLISON SAMPSON'S TRAUMA PRESENTATION

TRAUMA AND HUMAN SERVICE SYSTEMS

Within and between human service organizations we witness fight flight and freeze …

When we think about where this comes from … it is very similar to the experience of our clients

- We bring in our own ACE scores
- Our environments are stressful, demanding and sometimes abusive
  - Budget Cuts
  - Higher Caseloads
  - Increase paperwork demands
  - Higher expectations for outcomes and evidence informed practices
  - Constantly changing regulations
- Vicarious Trauma with and through our clients

SO WE DEVELOP COPING BEHAVIORS TO SURVIVE WITHIN AND BETWEEN THE SYSTEMS

- Remember … the “problems” we see in our clients are often their solutions to coping with stress and trauma

- Our challenges in and between our systems are often the way we cope within and between our agencies

- Fight/Flight/ Freeze can be our coping behaviors too

CROSS-SYSTEM CHALLENGES

- Adversarial Relationships
- Blaming other people or departments for ….
- Lack of Communication
- Avoiding Communication with certain People or Agencies
- Staying close only to those in “our circle”
- Doing nothing (waiting for the storm to pass)

CROSS SYSTEM CHALLENGES CAN ALSO BE BECAUSE OF …

- Lack of Knowledge
- Lack of Awareness
- Lack of True Collaboration
- Lack of Resources

TRAUMA PRESENT …

Trauma Informed Knowledge and Literature applies to human service professionals at all levels

- Clients
- Families
- Adults
- Professionals
- Agencies we are in
- Systems that work with each other

TRAUMA FUTURE

- HENRY’S STORY
- EMOTIONAL CHAIN OF CUSTODY

WHAT DOES IT MEAN TO BE TRAUMA INFORMED SYSTEM … NCTSN

A trauma-informed youth- and family-service system is one in which all parties involved recognize and respond to the impact of traumatic stress on those within the system including youth, caregivers, and service providers. Programs and agencies within such a system infuse and sustain trauma awareness, knowledge, and skills into their organizational cultures, practices, and policies. They collaborate with all those involved, using the best available science, to facilitate and support the recovery and resiliency of the youth and family.

A service system with a trauma-informed perspective is one in which programs, agencies, and service providers do the following:

1. Routinely screen for trauma exposure and related symptoms
2. Use culturally appropriate evidence-based assessment and treatment for traumatic stress and associated mental health symptoms
3. Make resources available to youth, families, and providers on trauma exposure, its impact, and treatment
4. Engage in efforts to strengthen the resilience and protective factors of youth and families affected by and vulnerable to trauma
5. Address parent and caregiver trauma and its impact on the family system
6. Emphasize continuity of care and collaboration across youth-serving systems
7. Maintain an environment of care for staff that addresses, reduces, and treats secondary traumatic stress and increases staff resilience

BECOMING A TRAUMA INFORMED ORGANIZATION …

National Council … 7 Domain Areas

Domain 1: Early Screening & Comprehensive Assessment of Trauma

Domain 2: Consumer Driven Care & Services

Domain 3: Trauma-Informed, Educated & Responsive Workforce

Domain 4: Provision of Trauma-Informed, Evidence-Based and Emerging Best Practices

Domain 5: Safe & Secure Environments

Domain 6: Community Outreach & Partnership Building

Domain 7: Ongoing Performance Improvement & Evaluation – Sustainability

DOMAIN 3 and 4

PREPARING OUR WORKFORCE TO OFFER TRAUMA INFORMED PHASE ORIENTED CARE

Phase I: Safety and Stabilization
Phase 2: Trauma Reprocessing
Phase 3: Reintegration

Courtois, C., Ford, J., & M. Cloitre (2009), pp.90-100

CORE AREAS OF FOCUS IN COMPLEX TRAUMA

COURTOIS, C. & FORD, J. (2009), INTRODUCTION (P.2)

- Self-Regulation
  - Affect Regulation
  - Disassociation (difficulty in being “present”)
  - Somatic Dysregulation
- Self-Identity
  - Impaired Self-Concept
  - Impaired Self-Development
- Co-regulation
  - Secure working model of caring relationship
  - Disorganized Attachment Patterns

DOMAIN 6

GREATER RICHMOND TRAUMA INFORMED COMMUNITY NETWORK (TICN)

- Question becomes where do I turn in my community for Resources? Education? Consultation?

- The Greater Richmond Trauma Informed Community Network (TICN) is a diverse group of professionals in your community dedicated to supporting all child welfare stakeholders in utilizing strengths based trauma informed practices in their work with children and families. In short, we are here to support and honor the important role you have in facilitating a positive environment for change in children and caregivers' lives using trauma informed practices to guide your way.

GREATER RICHMOND TICN MEMBERS

- Lynette Brinkerhoff, Children's Mental Health Resource Center
- Lynne Edwards, VDSS & Coordinators2
- Kim Flournoy-DiJoseph, VCU School of Social Work
- Jeanine Harper, Greater Richmond SCAN
- Hayley Matthews, Family and Children's Trust Fund of Virginia
- Nina Marino, Lutheran Family Services
- Melissa McGinn, Family Insight
- Fred Orelove, Professor Emeritus of Special Education at VCU
- Em Parente, VDSS
- Nicole Pries, ChildSavers
- Rebecca Ricardo, Coordinators2
- Kathy Ryan, Greater Richmond SCAN
- Allison Sampson, Family Preservation Services of VA
- Alli Ventura, VTCC/Children's Mental Health Resource Center
- Jan Williamson, Greater Richmond SCAN
- Lisa Wright, Greater Richmond SCAN
- Betty Jo Zarris, VDSS
- Trish Mullens, Chesterfield CSB (VCU- Masters in Rehabilitation)

10 PERCENT OF THE WORK DONE
90 PERCENT TO GO

WHAT WILL YOU DO ?

Understanding what we can do even better …

WHAT DOES IT MEAN TO BE TRAUMA INFORMED …

A trauma-informed youth- and family-service system is one in which all parties involved recognize and respond to the impact of traumatic stress on those within the system including youth, caregivers, and service providers. Programs and agencies within such a system infuse and sustain trauma awareness, knowledge, and skills into their organizational cultures, practices, and policies. They collaborate with all those involved, using the best available science, to facilitate and support the recovery and resiliency of the youth and family.

A service system with a trauma-informed perspective is one in which programs, agencies, and service providers do the following:

1. Routinely screen for trauma exposure and related symptoms
2. Use culturally appropriate evidence-based assessment and treatment for traumatic stress and associated mental health symptoms
3. Make resources available to youth, families, and providers on trauma exposure, its impact, and treatment
4. Engage in efforts to strengthen the resilience and protective factors of youth and families affected by and vulnerable to trauma
5. Address parent and caregiver trauma and its impact on the family system
6. Emphasize continuity of care and collaboration across youth-serving systems
7. Maintain an environment of care for staff that addresses, reduces, and treats secondary traumatic stress and increases staff resilience

ESSENTIAL ELEMENTS OF TICW

NCTSN CHILD WELFARE TOOLKIT (2008)

Maximize the child's sense of safety

- Physical and Psychological
- Provide clarity of what is happening

Assist children in reducing overwhelming conditions

- Remember "Trauma and the Brain"
- Help them regulate themselves so they can communicate, understand, and problem solve
- Remember the behavior you see may be coping with stress

Help children make new meaning of their trauma history & current experiences

- Remember impact of Trauma on the Brain and Attachment
- Remember implicit and explicit memory
- All of these factors impact information processing, communication and how the child makes sense out of what is happening

ESSENTIAL ELEMENTS OF TICW

NCTSN CHILD WELFARE TOOLKIT (2008)

Address the impact of the trauma and subsequent changes in the child's behavior

Coordinate services with other agencies

Utilize comprehensive assessment of the child's trauma experiences and their impact on the child's development and behavior to guide services

Support and Promote Positive and Stable Relationships in the life of the child

Manage professional and personal stress

IMPORTANT POINTS FOR TRAUMA INFORMED JUVENILE JUSTICE SYSTEMS (NCTSN … JUDGE AND JUVENILE JUSTICE BENCH CARD)

Structured case plans for probation, community supervision, and/or placement should consider the ability of the setting and the people involved to assist the child in feeling safe, valued, and respected. This is especially important for traumatized children. Similarly, the plan for returning home, for continuing school and education, and for additional court or probationary monitoring should also clearly address each child's unique concerns about safety, personal effectiveness, self-worth, and respect.

IMPORTANT POINTS FOR TRAUMA INFORMED JUVENILE JUSTICE SYSTEMS (NCTSN … JUDGE AND JUVENILE JUSTICE BENCH CARD)

Please consider …

Where, when, and with whom this child feels most safe, effective, valued and respected?

Where, when, and with whom does the child feel unsafe, ineffective or disrespected?

What out-of-home placements are available that can better provide for this child's health and safety, as well as for the community's safety?

What placements might encourage success in school, relationships, and personal development?

RECAP: COORDINATE SERVICES WITH OTHER AGENCIES.

- Traumatized children and their families are often involved with multiple service systems.
- Cross-system collaboration enables all helping professionals to see the child as a whole person, thus preventing potentially competing priorities and messages.
- Service providers should try to develop common protocols and frameworks for documenting trauma history, exchanging information, coordinating assessments, and planning and delivering care.

RECAP: PROVIDE SUPPORT AND GUIDANCE TO THE CHILD'S FAMILY AND CAREGIVERS.

- Children experience their world in the context of family relationships.
- Research has demonstrated that support from their caregivers is a key factor influencing children's psychological recovery from traumatic events.
- Resource families have some of the most challenging and emotionally draining roles in the entire child welfare system.
- Providing support and guidance to the child's family and caregivers is a part of federal outcomes (CFSR goals).

UNDERSTAND WHAT GOOD TRAUMA TREATMENT LOOKS LIKE …

- Phase Oriented Treatment " Gold Standard"

Phase I: Safety and Stabilization

Phase 2: Trauma Reprocessing

Phase 3: Reintegration

- Handout on questions to ask Mental Health Providers
- Resource http://www.nctsnet.org/nccts/nav.do?pid=ctr_top_trmnt_prom

PHASE ORIENTED TREATMENT

Phase Oriented Treatment for Trauma (Herman 1992, Janet 1889) from Courtois, C. "Treating Complex Traumatic Stress Disorders"

PHASE ONE: Safety and Stabilization

- Personal and Interpersonal Safety Established: Education/Support/Safety Planning
- Enhance Client's ability to manage extreme arousal (hyper/hypo)
- Active engagement in positive/negative experiences (deal with automatic avoidance behaviors, self awareness of avoidance, increase coping skills and use of coping skills)
- Education (psychotherapy, trauma, skills to be learned)
- Assess and develop relationship capacity (decrease avoidance of relationships or negative thoughts about relationships, build support network, define client's attachment network)

PHASE TWO: Trauma Reprocessing

- Disclosure of traumatic memories, development of an autobiographical narrative (identify emotions connected to trauma memories, grieve and mourn losses, resolution of relationships when appropriate, increased awareness, increase interpersonal and self-regulation skills)
- Supporting client in maintaining functioning and not getting lost in memories or seeing themselves as “disabled”, need to affirm strengths, promote positive self-esteem, and internal and external resources now available to them

PHASE THREE: Re-Integration

- Growth and period and reengagement in life
- Can be time of client realizing losses, discover of unresolved developmental deficits, fine tuning of self-regulation skills

AIM FORWARD (PHASE ONE)

PHASE 1: Acceptance

Specific Areas of Focus

- *Assess presenting problem (dominant story), meaning of behaviors and presence of adverse childhood experiences (ACEs)*
- *Explore client's current resources and strengths*
- *Co-develop a safety plan & actively use the safety plan to promote physical and emotional safety*
- *Establish therapeutic relationship which will promote a secure foundation for change*
- *Connect client and families to support systems that can help to facilitate positive change*
- *Create a collaborative treatment plan for short & long term goals and brainstorm solutions*
- *Clarify expectations and roles for clients and professionals throughout the treatment process*
- *Educate client and stakeholders in effective interventions*
- *Identify healthy coping skills that will reduce stress and physiological dysregulation*
- *Begin education and practice of skills that will enhance self-regulation and co-regulation*

AIM FORWARD (PHASE 2)

Integration

Specific Areas of Focus

- *Identify potential barriers to integrating new coping skills*
- *Educate client in the problem solving model*
- *Bolster client strengths, support systems and expanded resources (alternate story) to enhance client's problem solving abilities and the achievement of targeted goals*
- *Incorporate new skills into client's autobiographical narrative to enhance self esteem and create an optimistic perspective on client's own ability to solve problems*
- *When needed, reprocess traumatic memories to enhance self-regulation and improve ability to engage in present focused problem solving strategies*

AIM FORWARD (PHASE 3)

MOVING FORWARD

The final phase of treatment focuses on supporting the client in mastering skills learned in the other two phases, addressing unhealthy coping behaviors when they occur, solidifying successes in achieving treatment goals, amplifying new skills in other life domain areas and creating a future life plan that includes ongoing skill practice and development as new life challenges occur (relapse prevention).

Specific Areas of Focus

- Incorporate new skills into daily living practices to enhance quality of life
- Enhance awareness of potential risk factors that may arise in the future and practice applying skills to solve new life challenges
- Amplify strengths and coping solutions into multiple life domain areas to improve overall well-being and exemplify how future life challenges can be approached using similar coping skills and problem solving approaches
- Create a future life plan that focuses on the client's ongoing goals for well-being including physical and mental health

WHAT IS NEXT FOR YOUR AGENCY?

- Trauma Informed Child Welfare and Juvenile Justice approaches are a lens you can use to define the way you …

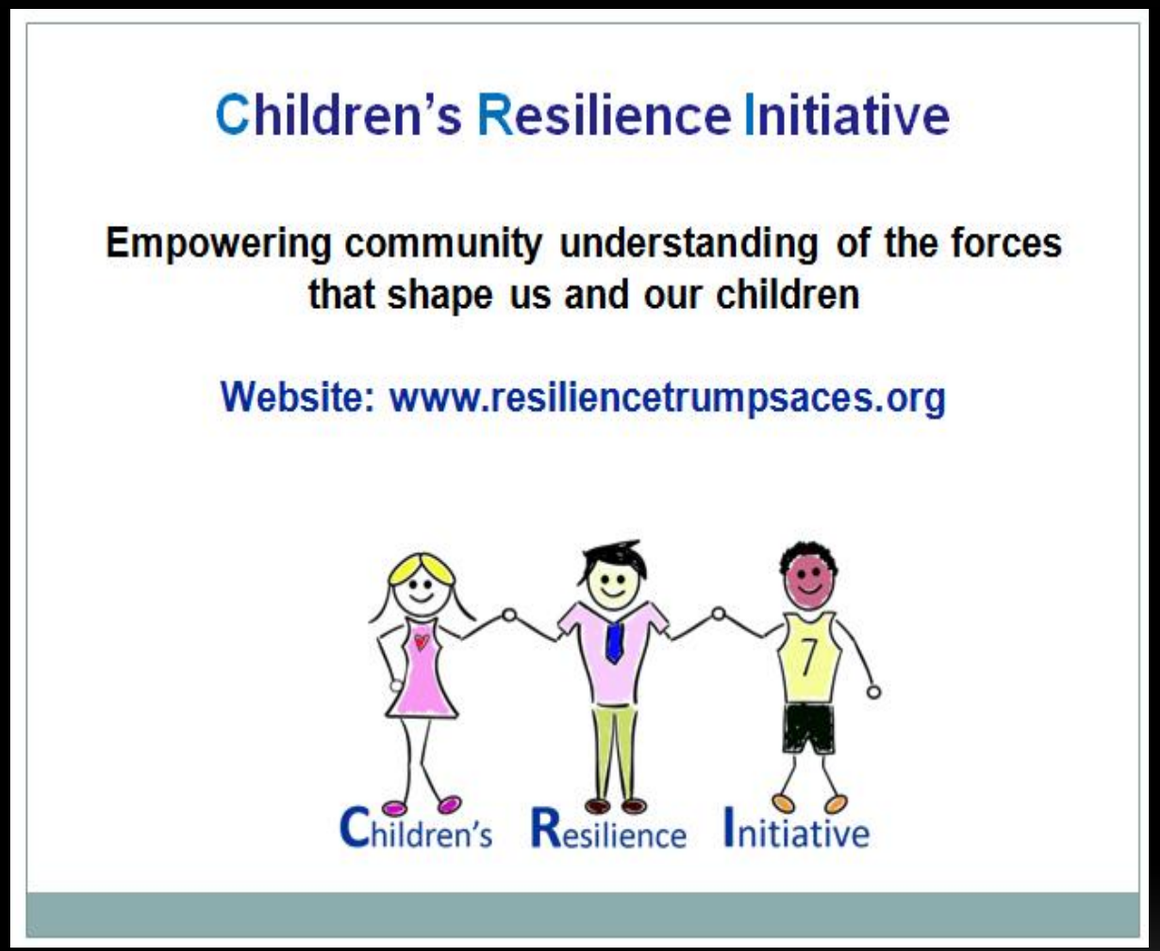
  - - Screen and Assess children and families
  - - Gather information from clients and families about the services they need and are receiving from you
  - - Educate your workforce
  - - Make decisions about referrals to trauma informed and evidence informed programs
  - -Create safe and secure environments (physically and emotionally)
  - - Engage in Community Outreach and Partnership Building
  - - Make decisions about ongoing performance of your work, your agency and the quality of the work you offer

GUIDED DISCUSSION …

- We want to offer you the opportunity to use the next 15-20 minutes to think about what you want to do next?

- What is your biggest take away so far from today … what resonates?
- Where do you want to start to enhance the trauma informed services you provide in your role? Your agency?
- What partnerships will you harness?
- What resources do you need?
- What types of education and development tools will you and your workforce need?
- Brainstorm and create 3 next action steps for yourself and your agency

RESILIENCE TRUMPS ACES



FROM TRISH MULLEN, CHESTERFIELD COMMUNITY SERVICES BOARD

POST-TRAUMATIC GROWTH

TEDESCHI AND CALHOUN (1996, 1999, 2006)

1) Emergence of new opportunities and possibilities
2) Deeper relationships and greater compassion for others
3) Feeling strengthened to meet future life challenges
4) Reorder priorities and fuller appreciation of life
5) Deepening spirituality

http://cust-cf.apa.org/ptgi/

FAMILIES WHO THRIVE

Characteristics of Families who Thrive

Figley and Kiser (2013) Helping Traumatized Families (pg. 39-41)

- ☐ Clear acceptance of stressor(s)
- ☐ Family centered locus of problem (shift from individual)
- ☐ Solution oriented problem solving (not blame)
- ☐ High tolerance for each other
- ☐ Clear and direct expressions of commitment and affections
- ☐ Open and Effective Communication
- ☐ High Family Cohesion (fun and enjoyment)
- ☐ Flexible Family Roles
- ☐ Predictability
- ☐ Effective resource utilization
- ☐ Belief in their ability to succeed
- ☐ Shared meaning (collaborative coping skills)

BOLSTER PROTECTIVE FACTORS

- Positive attitudes, values or beliefs
- Conflict resolution skills
- Good mental, physical, spiritual and emotional health
- Positive self-esteem
- Success at school
- Good parenting skills
- Parental supervision
- Strong social supports
- Community engagement
- Problem-solving skills
- Positive adult role models, coaches, mentors
- Healthy prenatal and early childhood development
- Participation in traditional healing and cultural activities
- Good peer group/friends
- Steady employment
- Stable housing
- Availability of services (social, recreational, cultural, etc)